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Quality Payment Program Year 2: Final Rule Highlights

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Quality Payment Program Year 2

Topics

- Overview
  - Quality Payment Program Final Rule
  - Patients Over Paperwork
- What's new for Year Two
  - Merit-based Incentive Payment System (MIPS) Highlights
  - Alternative Payment Models (APMs) Highlights
- Pros & Cons
- Resources
- Appendix
  - QPP Final Policies Comparison – Years 1 & 2

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QUALITY PAYMENT PROGRAM Year 2

Overview

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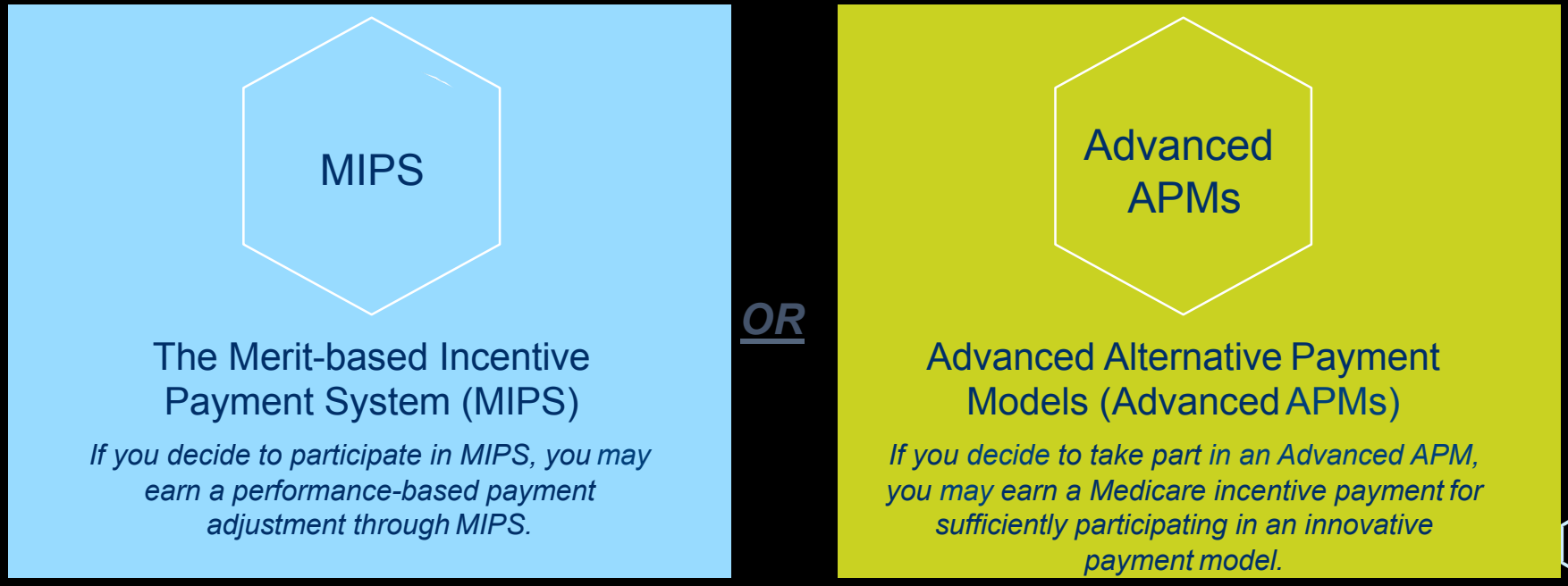
Quality Payment Program Final Rule

The Quality Payment Program:

- Is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).
- CMS listened to stakeholder feedback and used it to ensure that QPP Year 2 :
  - Measures and activities are meaningful
  - Clinician burden is minimized
  - Care coordination is better
  - Clinicians have a clear way to participate in Advanced APMs



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Quality Payment Program Final Rule

Year 2 Considerations

Keeping many flexibilities from transition year to help readiness for Year 3

Final Rule with comment period

Major changes to how Medicare pays clinicians

Ease burden to maximize participation

Offering new incentives for participation

Slowing down to prepare clinicians for full implementation in year 3

Continue offering free, hands-on Technical Assistance

Quick Tip: For additional information on the Quality Payment Program, visit qpp.cms.gov

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Patients Over Paperwork

QPP final rule includes the following as part of this initiative:

- Excludes individual MIPS eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries.
- Addresses extreme and uncontrollable circumstances, such as hurricanes and other natural disasters, for both the transition year and the 2018 MIPS performance period.
- Includes virtual groups as another participation option for year 2.
- Makes it easier for clinicians to qualify for incentive payments by participating in Advanced APMs that begin or end in the middle of a year.

FINAL RULE FOR YEAR 2

Merit-based Incentive Payment System Highlights

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Final Rule for Year 2

MIPS: Highlights

- Raising performance threshold to 15 points
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2
- Bonus for using only 2015 CEHRT
- 5 bonus points on final score for treatment of complex patients
- Adding 5 bonus points to the final scores of small practices
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the final score for clinicians impacted by hurricanes Irma, Harvey and Maria and other natural disasters

Final Rule for Year 2

MIPS: Small Practices – More options, tailored flexibilities for groups 15 or less

- Excluding individual MIPS eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries
- Giving solo practitioners and small practices the choice to form or join a Virtual Group to participate with other practices
- Continuing to award small practices 3 points for measures in the Quality performance category that don't meet data completeness requirements
- Adding a new hardship exception for the Advancing Care Information performance category for small practices

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Final Rule for Year 2

MIPS: Gradual Implementation

Minor changes to the policies to ensure that clinicians are ready for full implementation in year 3:

- Weighting the MIPS Cost performance category to 10% of your total MIPS final score.
- Including the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures to calculate your Cost performance category score for the 2018 MIPS performance period.
- These two measures carried over from the Value Modifier program and are currently being used to provide feedback for the MIPS transition year. CMS will calculate cost measure performance; no action is required from clinicians.
- Increasing the performance threshold to 15 points in Year 2 (from 3 points in the transition year).
- Continuing a phased approach to public reporting Quality Payment Program performance information on Physician Compare.

Final Rule for Year 2

MIPS: Extreme and Uncontrollable Circumstances

Addressed extreme and uncontrollable circumstances for both the transition year and the 2018 MIPS performance period

- For the transition year, if a MIPS eligible clinician's CEHRT is unavailable as a result of extreme and uncontrollable circumstances (e.g., a hurricane, natural disaster, or public health emergency), the clinician may submit a hardship exception application to be considered for reweighting of the Advancing Care Information performance category. This application is due by **December 31, 2017**.
- Extends reweighting policy for the three other performance categories (Quality, Cost, and Improvement Activities) starting with the 2018 MIPS performance period. This hardship exception application deadline is **December 31, 2018**.
- Issuing an interim final rule for automatic extreme and uncontrollable circumstances where clinicians can be exempt from these categories in the transition year without submitting a hardship exception application (note that cost has a 0% weight in the transition year) due to policies relating to reweighting the Quality, Cost, and Improvement Activities performance categories not effective until next year.

Final Rule for Year 2

MIPS: Extreme and Uncontrollable Circumstances

What does this mean for 2017 MIPS performance period?

- Clinicians in affected areas that do not submit data will not have a negative adjustment.
- Clinicians that do submit data will be scored on their submitted data. To get a positive payment adjustment clinicians have to submit data on two or more performance categories
- The policy applies to individuals (not group submissions).
- This policy does not apply to APMs.

Note: If a MIPS eligible clinician who is eligible for reweighting due to extreme and uncontrollable circumstances, but still chooses to report (as an individual or group), they will be scored on that performance category based on their results.

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Final Rule for Year 2

MIPS: 21st Century Cures Act

Contains provisions affecting the Advancing Care Information performance category for the QPP current transition year and future years.

21st Century Cures Act provisions

- Reweighting the Advancing Care Information performance category to 0% of the final score for ambulatory surgical center (ASC)-based MIPS eligible clinicians.

- Using the 21st Century Cures Act authority for significant hardship exceptions and hospital-based MIPS eligible clinicians to reweight the Advancing Care Information performance category to 0% of the final score.

Final Rule for Year 2

MIPS: Virtual Groups

- Inclusion of Virtual Groups as another participation option
- A Virtual Group is a combination of two or more Taxpayer Identification Numbers (TINs) composed of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter specialty or location) to participate in MIPS for a performance period of a year.
- CMS developed a Virtual Groups Toolkit which contains the following:
  - Virtual Groups Overview Fact Sheet
  - Virtual Groups Election Process Fact Sheet
  - Virtual Group Agreement Checklist
  - Virtual Group Agreement Template

FINAL RULE FOR YEAR 2

APM Highlights

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Final Rule for Year 2

APM Highlights

- Final Rule provides more details on how CMS will incentivize clinicians who participate in APMs offered by payers other than Medicare, starting in 2019
- Updated policies to further encourage and reward participation in APMs in Medicare:
  - Better Coordination and Promoting Alignment
  - Increasing APM Participation
  - Reducing Complexity

Final Rule for Year 2

APM：Better Coordination and Promoting Alignment

Aligns the standards that apply to Medicare and Other Payer Advanced APMs more closely

Policies:

- Establishing a generally applicable revenue-based nominal amount standard for Other Payer Advanced APMs.
- This standard allows a non-Medicare payment arrangement to meet the financial risk criterion to qualify as an Other Payer Advanced APM if participants are required to bear total risk of at least 8% of their revenues from a given payer.

Final Rule for Year 2

APM：Increasing APM Participation

Includes provisions to make it easier for eligible clinicians to participate in select APMs (known as Advanced APMs), which may allow them to qualify for incentive payments.

Policies:

- Extending the 8% generally applicable revenue based nominal amount standard that allows APMs to qualify as Advanced APM for two additional years, through performance year 2020.
- Exempting Round 1 Comprehensive Primary Care Plus participants certain currently participating clinicians from the 50 clinician limit on organizations that can earn incentive payments by participating in medical home models.
- Changing the requirement for Medical Home Models so that the minimum required amount of total financial risk increases more slowly.
- Making it easier for clinicians to qualify for incentive payments by participating in Advanced APMs that begin or end in the middle of a year.

Final Rule for Year 2

APM：Reducing Complexity

Includes provisions to make it easier for eligible clinicians to participate in select APMs (known as Advanced APMs), which may allow them to qualify for incentive payments.

Policies:

- More detail on how eligible clinicians participating in selected APMs (known as MIPS APMs) will be assessed under the APM scoring standard.
  - This special standard reduces burden for MIPS APM participants who do not qualify as Qualifying APM Participants (QPs), and are therefore subject to MIPS.
- Elaborated on how the All-Payer Combination Option will be implemented.
  - Allows clinicians to become QPs through a combination of Medicare participation in Advanced APMs and participation in Other Payer Advanced APMs.
  - Available beginning in performance year 2019.
- Created, where possible, additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option.
- Changing the requirement for Medical Home Models so that the minimum required amount of total financial risk increases more slowly.

QUALITY PAYMENT PROGRAM

PROS & CONS by Industry Associations

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Final Rule for Year 2

American Medical Group Association (AMGA),
National Committee for Quality Assurance (NCQA) &
Medical Group Management Association (MGMA)

PROS –

- Gradually ramping up participation – “Pick your own Pace”
- MIPS reporting and attestation flexibilities
- More MIPS measures to select from (over 270 quality measures & 90 improvement activities)
- Gradually increasing the number of measures needed
- Penalties and bonuses ramp up year after year and start small
- Valuable resources available

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Final Rule for Year 2

CONS

- Slow the value-based care transition AMGA
- Participation thresholds excludes more Medicare providers from attesting to MIPS in 2018
    - Taking accountability for the quality and cost of care requires years of experience
- Rule hinders the prospects for value-based care
- Increasing the number of excluded providers would impact virtual group implementation
- Increasing quality reporting period in year 2 does not promote quality

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QUALITY PAYMENT PROGRAM

Resources

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QPP Resources

Available Resources

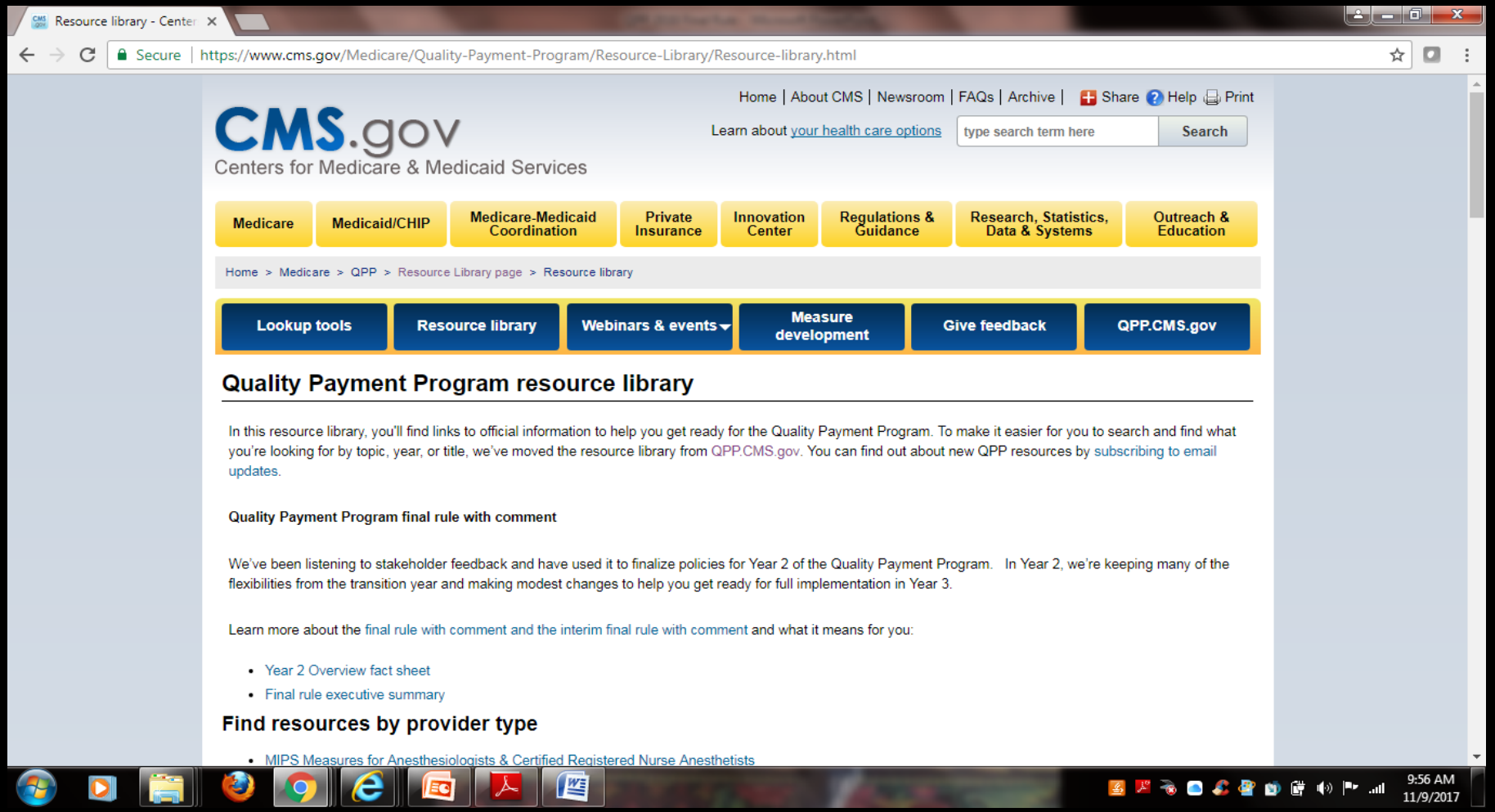
CMS offers a range of resources and support to help you actively participate in QPP:

- Videos
- Online Courses
- Webinars
- Technical Assistance 1-866-288-8292
- Peer-based Learning Network – Practice Transformation Networks (PTN)
- In-person Assistance – cost free
- APM Learning Systems Innovation.cms.gov
- Developer Tools
- Peer-based Learning Network –

QPP Resource Library

The resource library got moved to CMS.gov

Search by topic, year or title go to:
https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html



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QUALITY PAYMENT PROGRAM

Feedback

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CMS wants to hear from you

User-centered approach

CMS wants to hear from the health care community on the final rule with comment period and interim final rule and the implications for clinicians in Year 2, as well as on their message and education delivery. To give feedback or host a listening session, please contact CMS at QPP@cms.hhs.gov.

Comment on 2018 Final Rule

How to Comment on the Final Rule with Comment Period
(and Interim Final Rule (CMS-5522-IFC))

Four ways to submit comments (must choose only one):

- Electronically to http://www.regulations.gov/ follow the “Submit a comment” instructions.
- By regular mail – Mail written comments to:
  Centers for Medicare &Medicaid Services,
  Department of Health and Human Services,
  Attention: CMS–5522–FC or CMS-5522-IFC (as appropriate),
  P.O. Box 8016, Baltimore, MD 21244–8016
- By express or overnight mail
- By hand or courier

Note: Please refer to file code CMS–5522–FC when commenting on issues in the final rule with comment period, and CMS-5522-IFC when commenting on issues in the interim final rule with comment period.

QUALITY PAYMENT PROGRAM

Appendix - Final Policies Comparison Years 1 & 2

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Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Low-volume threshold	• You're excluded if you or your group has ≤$30,000 in Part B allowed charges OR ≤100 Part B beneficiaries.	• You're excluded if you or your group has ≤$90,000 in Part B allowed charges or ≤200 Part B beneficiaries.
Non-patient facing	• Individual - If you have ≤100 patient facing encounters. • Groups - If your group has > 75% NPIs billing under your group's TIN during a performance period considered as non-patient facing.	• Individual and Group policy: No change. • Virtual Groups have same definition as groups. Virtual Groups that have > 75% NPIs billing under the Virtual Group's TINs during a performance period who are non-patient facing.
Ways to submit	•You use only 1 submission mechanism per performance category.	• No change for Year 2. Delayed until 2019 MIPS performance period. • For Year 3, you'll be able to use multiple submission mechanisms.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Virtual Groups	• Not an option for the transition year.	• Added Virtual Groups as a way to participate for Year 2. Virtual Groups can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period of a year. • Solo practitioners and small groups may only participate in a Virtual Group if you exceed the low-volume threshold. • The MIPS payment adjustments will only apply to the MIPS eligible clinicians in a Virtual Group. • If the group chooses to join or form a Virtual Group, all eligible clinicians under the TIN would have their performance assessed as part of the Virtual Group.

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Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Virtual Groups	• Not an option for the transition year.	• Components are finalized for a formal written agreement between each member of the Virtual Group. • Election process for 2018 runs from October 11 – December 31, 2017. • If certain members of a Virtual Group are in a MIPS APM, we'll apply the APM Special Scoring Standard instead of the Virtual Group score. • Generally, policies that apply to groups would apply to Virtual Groups. Differences include: ▪ Definition of non-patient facing MIPS eligible clinician. ▪ Small practice status. ▪ Rural area and Health Professional Shortage Area designations.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Quality	• Not available in current transition year.	• Not available in year 2. Due to operational constraints, the facility-based measurement proposal was delayed until year 3 of the Quality Payment Program (2019 performance year and 2021 payment year).
Quality	**Weight to final score:** • 60% in 2019 payment year. • 50% in 2020 payment year. • 30% in 2021 payment year and beyond.	**Weight to final score:** • Finalized at 50% in 2020 payment year. • 30% in 2021 payment year and beyond.
Quality	**Data completeness:** • 50% for submission mechanisms except for Web Interface and CAHPS. • Measures that don't meet the data completeness criteria earn 3 points.	**Data completeness:** • 60% for submission mechanisms except for Web Interface and CAHPS. • Measures that don't meet the data completeness criteria will earn 1 point, except for a measure submitted by a small practice, which will earn 3 points.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Quality	**Scoring:** • 3-point floor for measures scored against a benchmark. • 3 points for measures that don't have a benchmark or don't meet case minimum requirements. • Bonus for additional high priority measures up to 10% of denominator for performance category. • Bonus for end-to-end electronic reporting up to 10% of denominator for performance category.	**Scoring:** • No change for year 2.
Quality/ topped out quality measures	• Not applicable for the transition year.	• Topped-out measures will be removed and scored on 4 year phasing out timeline. • Topped out measures with measure benchmarks that have been topped out for at least 2 consecutive years will earn up to 7 points.

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Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Quality/ topped out quality measures	• Not applicable for the transition year.	• The 7-point scoring policy for 6 topped out measures identified for the 2018 performance period is finalized. These 6 topped out measures include the following: ▪ Perioperative Care: Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin. (Quality Measure ID: 21) ▪ Melanoma: Overutilization of Imaging Studies in Melanoma. (Quality Measure ID: 224) ▪ Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients). (Quality Measure ID: 23) ▪ Image Confirmation of Successful Excision of Image-Localized Breast Lesion. (Quality Measure ID: 262)

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Quality/ topped out quality measures	• Not applicable for the transition year.	▪ Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description (Quality Measure ID: 359) ▪ Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Quality Measure ID: 52) • Topped out policies do not apply to CMS Web Interface measures, and CMS will monitor for differences with other submission options. • CAHPS will be addressed in future rulemaking.

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Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Cost	**Weight to final score:** • 0% in 2019 payment year.	**Weight to final score:** • Finalized at 10% in 2020 payment year. • 30% in 2021 MIPS payment year and beyond.
	Measures: • Includes the Medicare Spending per Beneficiary (MSPB), total per capita cost measures, and 10 episode-based cost measures.	**Measures:** • Includes the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures for the Cost performance category for the 2018 MIPS performance period. • For the 2018 MIPS performance period, we won't use the 10 episode-based measures adopted for the 2017 MIPS performance period. • We are developing new episode-based measures with stakeholder input and soliciting feedback on some of these measures fall 2018. • We expect to propose new cost measures in future rulemaking and solicit feedback on episode-based measures before they are included in MIPS.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Cost	**Reporting/Scoring:** • We'll calculate individual MIPS eligible clinician's and group's Cost performance using administrative claims data if they meet the case minimum of attributed patients for a measure and if a benchmark has been calculated for a measure. • Individual MIPS eligible clinicians and groups don't have to submit any other information for the Cost performance category. • We compare your performance with the performance of other MIPS eligible clinicians and groups during the performance period so measure benchmarks aren't based on a previous year. • Performance category score is the average of the 2 measures. • If only 1 measure can be scored, that score will be the performance category score.	**Reporting/Scoring:** No change

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Improvement scoring for Quality & Cost	• Doesn't apply in the current transition year.	**For Quality:** • We'll measure improvement at the performance category level. • Up to 10 percentage points available in the Quality performance category. **For Cost:** • We'll base improvement scoring on statistically significant changes at the measure level. • Up to 1 percentage point available in the Cost performance category. **For Quality and Cost:** • If the improvement score can't be calculated because there is not sufficient data, we'll assign an improvement score of 0 percentage points. • CMS will figure an improvement score only when there's sufficient data to measure improvement (e.g., MIPS eligible clinician uses the same identifier in 2 consecutive performance periods and is scored on the same cost measure(s) for 2 consecutive performance periods).

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Improvement Activities	**Weight to final score:** •15% and we measure it based on a selection of different medium and high-weighted activities.	**Weight to final score:** • No change for the 2020 payment year
	Number of activities: • We included 92 activities in the Inventory. • Small practices; practices in rural areas, geographic health professional shortage areas (HPSAs); and non-patient facing MIPS eligible clinicians don't need more than 2 activities (2 medium or 1 high-weighted activity) to earn the full score. • All other MIPS eligible clinicians don't need more than 4 activities (4 medium or 2 high-weighted activities, or a combination).	**Number of activities:** • Finalized more activities and changes to existing activities; for a total of approximately 112 activities in the inventory. • Requirements for small practices, practices in rural areas, geographic HPSAs, and non-patient facing MIPS eligible clinicians: no change. • No change in the number of activities that you need to report to reach a maximum of 40 points.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Improvement Activities	**Definition of certified patient-centered medical home:** • Includes accreditation as a patient-centered medical home from 1 of 4 nationally-recognized accreditation organizations; a Medicaid Medical Home Model or Medical Home Model; NCQA patient-centered specialty recognition; and certification from other payer, state or regional programs as a patient-centered medical home if the certifying body has 500 or more certified member practices. • Only 1 practice within a TIN has to be a patient-centered medical home or comparable specialty practice for the TIN to get full credit in the category.	**Definition of certified patient-centered medical home:** • We've finalized the term "recognized" to mean the same as "certified" as a patient-centered medical home or comparable specialty practice. • We've finalized a 50% threshold for 2018 for the number of practice sites within a TIN that need to be patient-centered medical homes for that TIN to get full credit for the Improvement Activities performance category.
	Scoring: • All APMs get at least ½ of the highest score but we'll give MIPS APMs an additional score, which may be higher than one half of the highest potential score based on their model. All other APMs must choose other activities to get additional points for the highest score.	**Scoring:** • No change to the scoring policy for APMs and MIPS APMs. • We've kept some activities in the performance category that also qualify for an Advancing Care Information bonus.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Improvement Activities	• Some activities qualify for Advancing Care Information bonus. • For group participation, only 1 MIPS eligible clinician in a TIN has to perform the Improvement Activity for the TIN to get credit.	• For group participation, only 1 MIPS eligible clinician in a TIN has to perform the Improvement Activity for the TIN to get credit. • We allow simple attestation of Improvement Activities.
Advancing Care Information	**CEHRT requirements:** • Can use either 2014 or 2015 Edition CEHRT for the 2017 transition year.	**CEHRT requirements:** • No change for 2018 • A 10% bonus is available if you only use the 2015 Edition CEHRT.
	Scoring: • Award a base score of 50% if you submit the numerator (of at least "1") and denominator, or "yes" for the yes/no measure, for each required measure. If the base score isn't met, you'll get a 0 for the Advancing Care Information category.	**Scoring:** • No change to the base score requirements for the 2020 payment year. • For the performance score, you or your group may earn 10% in the performance score for reporting to any single public health agency or clinical data registry.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Advancing Care Information	• Awarded performance score points if you submit additional measures (up to 10% each). • Give a bonus score (5%) for submitting to 1 or more additional public health agencies or clinical data registries. • Give bonus points (10%) when you use CEHRT to complete at least 1 of the specified Improvement Activities.	• A 5% bonus score is available for submitting to an additional public health agency or clinical data registry not reported under the performance score. • Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus if you use CEHRT to complete at least 1 of the specified Improvement Activities.
	Exceptions: • We reweighted the Advancing Care Information performance category to 0% of the final score and reallocate the weight to the Quality performance category if there are not sufficient measures applicable and available for a clinician	**Exceptions:** • Based on authority from the 21st Century Cures Act, we'll reweight the Advancing Care Information performance category to 0% of the final score and reallocate the performance category weight of 25% to the Quality performance category for: ▪ A significant hardship exception—We won't apply a 5-year limit to this exception;

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Advancing Care Information		▪ A new significant hardship exception for MIPS eligible clinicians in small practices (15 or fewer clinicians); ▪ An exception for hospital-based MIPS eligible clinicians; ▪ A new exception for Ambulatory Surgical Center (ASC)-based MIPS eligible clinicians, finalized to apply beginning with the transition year; and ▪ A new exception for MIPS eligible clinicians whose EHR was decertified. • New deadline of December 31 of the performance period for the submission of reweighting applications, beginning with the 2017 performance period. • We've revised the definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19). **Measures and Objectives:** • We have finalized exclusions for the E-Prescribing and Health Information Exchange Measures, for the transition year.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Complex patients bonus	• Not available in the current transition year.	•Clinicians can earn up to 5 bonus points for the treatment of complex patients (based on a combination of the Hierarchical Condition Categories (HCCs) and the number of dually eligible patients treated).
Small practice bonus	• Not available in the current transition year	• Added 5 points to any MIPS eligible clinician or small group who's in a small practice (defined as 15 or fewer eligible clinicians), as long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.
Final score	**2017 MIPS performance period final score:** • Performance category weight: Quality 60%, Cost 0%, Improvement Activities 15%, and Advancing Care Information 25%.	**2018 MIPS performance year final score:** • Performance category weight: Quality 50%, Cost 10%, Improvement Activities 15%, and Advancing Care Information 25%.

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Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Performance threshold/ Payment adjustment	• Performance threshold is set at 3 points. • Additional performance threshold set at 70 points for exceptional performance. • Payment adjustment for the 2019 payment year ranges from - 4% to + (4% x scaling factor not to exceed 3) as required by law. (We'll figure the scaling factor to get to budget neutrality.) •Additional payment adjustment for exceptional performance starts at 0.5% and goes up to 10% x scaling factor not to exceed 1.	• We've set the performance threshold at 15 points. • Additional performance threshold stays at 70 points for exceptional performance. • Payment adjustment for the 2020 payment year ranges from - 5% to + (5% x scaling factor not to exceed 3) as required by law. (The scaling factor is determined in a way so that budget neutrality is achieved.) • Additional payment adjustment calculation is the same as in 2017. • We'll apply the payment adjustment to the amount Medicare pays.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS POLICY		
Performance period	• Minimum 90-day performance period for Quality, Advancing Care Information, and Improvement Activities. • Exception: measures through CMS Web Interface, CAHPS, and the readmission measure are for 12 months. • We'll measure Cost for 12 months.	• No change for Advancing Care Information and Improvement Activities. • Minimum 12 month performance period for Quality. • No change to the exception

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Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
ADVANCED APM POLICIES		
Generally applicable nominal amount standard	• Total potential risk under the APM must be equal to at least: either 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018 (the revenue-based standard), OR 3% of the expected expenditures that an APM Entity is responsible for under the APM for all performance years.	• We've extended the 8% revenue-based standard for 2 additional years, through performance year 2020.
Medical Home Model financial risk standard	• Starting in the 2018 QP performance period, the Medical Home Model financial risk standard wouldn't apply for APM Entities that are owned and operated by organizations with more than 50 eligible clinicians.	• We are keeping the "50 eligible clinician cap" in place except for clinicians who are participating in the first round of the Comprehensive Primary Care Plus (CPC+) model.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
ADVANCED APM POLICIES		
Medical Home Model nominal amount standard	The total potential risk for an APM Entity under the Medical Home Model standard has to be equal to at least: • 2.5% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2017. • 3% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2018. • 4% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2019. • 5% of the estimated average total Parts A and B revenue of participating APM Entities for performance year 2020.	We are finalizing that the minimum total potential risk for an APM Entity under the Medical Home Model standard is adjusted to: • 2.5% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance year 2018. • 3% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for the QP performance period in 2019. • 4% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance year 2020. • 5% of the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities for performance years 2021 and after.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
ADVANCED APM POLICIES		
Qualifying APM participant (QP) performance period & QP & partial QP determination	• Beginning in 2017, the QP performance period will be January 1 – August 31 each year. • We'll make 3 QP determinations using data from March 31, through June 30, and through the last day of the QP performance period, respectively.	•The QP performance period stays the same. • The timeframe on which the payment/patient threshold calculations is based is modified for certain Advanced APMs. For Advanced APMs that start or end during the QP performance period, QP Threshold Scores are calculated using only the dates that APM Entities were able to participate in the Advanced APM, as long as they were able to participate for at least 60 continuous days during the QP performance period.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
ALL-PAYER COMBINATION OPTION/OTHER PAYER ADVANCED APM POLICY		
Generally applicable nominal amount standard for Other Payer Advanced APMs	• Nominal amount of risk must be: ▪ Marginal risk of at least 30%; ▪ Minimum Loss Rate of no more than 4%; and ▪ Total risk of at least 3% of the expected expenditures the APM Entity is responsible for under the APM.	• For performance years 2019 and 2020, we've added a revenue-based nominal amount standard of 8% that only applies to payer arrangements where the risk for APM Entities is expressly defined in terms of revenue. This is an additional option and wouldn't replace or supersede the expenditure-based standard we previously finalized.
All-Payer Combination Option QP performance period	• Beginning in 2019, the QP performance period will be January 1 – August 31 each year. • We'll make 3 QP determinations (Q1, Q2, and Q3) using data available through March 31, through June 30, and through the last day of the QP performance period, respectively.	• As we do for the Medicare Option, we will make QP determinations based on three snapshots dates: March 31, June 30, and August 31. We are finalizing our proposal that an eligible clinician would need to meet the relevant QP or Partial QP threshold under the All-Payer Combination Option as of one of these three dates, and to use data for the same time periods for Medicare and other payer payments or patients in making QP determinations.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
ALL-PAYER COMBINATION OPTION/OTHER PAYER ADVANCED APM POLICY		
Payer-initiated determination of Other Payer Advanced APMs	• We didn't address this in the CY 2017 Final Rule.	• Starting in performance year 2019, payers can submit payment arrangements authorized under Title XIX (Medicaid), Medicare Health Plan payment arrangements (including Medicare Advantage), and payment arrangements aligned with a CMS Multi-Payer Model and request that we make Other Payer Advanced APM determinations before the relevant QP Performance Period. • We intend to offer this option to remaining other payers including commercial and other private payers in future years.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
ALL-PAYER COMBINATION OPTION/OTHER PAYER ADVANCED APM POLICY		
All-Payer Combination Option QP determinations	• QP determinations under the All-Payer Combination Option would be made at either the APM Entity or individual eligible clinician level, depending on the circumstances.	• For purposes of QP determinations under the All-Payer Combination Option, eligible clinicians will have the option to either be assessed at the individual level or at the APM Entity level. • If the Medicare threshold score for an eligible clinician is higher when calculated for the APM Entity group than when calculated for the individual eligible clinician, we'll make the QP determination under the All-Payer Combination Option using a weighted Medicare threshold score that will be factored into All-Payer Combination Option threshold score calculated at the individual eligible clinician level.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
ALL-PAYER COMBINATION OPTION/OTHER PAYER ADVANCED APM POLICY		
Eligible Clinician Initiated Submission of Information and Data as Part of the All-Payer Combination Option	• To be assessed under the All-Payer Combination Option, APM Entities or eligible clinicians would be required to provide us with this information: ▪ Payment arrangement information we need to assess the other payer arrangement on all Other Payer Advanced APM criteria. ▪ For each other payment arrangement, the amount of revenues for services given through that arrangement, the total revenues from the payer, the number of patients furnished any service through the arrangement, and the total number of patients furnished any service through the payer. ▪ An attestation from the payer that the submitted information is correct.	• If we haven't already made the determination through the Payer-Initiated process, APM Entities or eligible clinicians can submit information about their payment arrangements to us and ask us to make Other Payer Advanced APM determinations. • We've eliminated the requirement for a payer attestation; APM Entities or eligible clinicians have to certify that the information they submit is accurate.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS APM/APM SCORING STANDARD POLICY		
Identifying MIPS APM participants	• A clinician on an APM Participation List on at least 1 of the APM participation assessment (Participation List "snapshot") date, you'll be included in the APM Entity group for the APM scoring standard for the applicable performance year. If you aren't on the APM Entity's Participation List on at least one of the snapshot dates (March 31, June 30, or August 31), then you'll need to submit data to MIPS using the MIPS individual or group participation option and meet all generally applicable MIPS data submission requirements in order to avoid a negative payment adjustment.	• Adding December 31 as a fourth snapshot date to determine participation in Full TIN MIPS APMs (currently applies to participation in the Medicare Shared Savings Program only). • Won't use the fourth snapshot date to make QP determinations or extend the QP performance period past August 31.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS APM/APM SCORING STANDARD POLICY		
Virtual Groups & MIPS APMs	• Not applicable for the transition year.	• For MIPS APMs, we're waiving sections of the statute that require all Virtual Group participants to receive their MIPS payment adjustment based on the Virtual Group score. This means that participants in APM Entities in MIPS APMs who are also participating in a Virtual Group would receive their MIPS payment adjustment based on their APM Entity score under the APM scoring standard.
Quality performance category	• Use quality measure data reported through the APM. • 50% weight for Medicare Shared Savings Program ACOs, Next Generation ACO Model in the first year. • 0% weight for other MIPS APMs in the first year.	• Use quality measure data reported through the APM. • Performance category weight = 50%. • Quality Improvement points will be available beginning in the 2018 performance year for any APM Entity for which 2017 quality performance data are available.

Quality Payment Program

Final Policies Comparison Years 1 & 2

Policy Topic	Transition Year 1 (Final Rule CY 2017)	Year 2 (Final Rule CY 2018)
MIPS APM/APM SCORING STANDARD POLICY		
Improvement Activities performance category	• 20% weight for Medicare Shared Savings Program ACOs, Next Generation ACO model. • 25% weight for other MIPS APMs for first year. • We'll automatically assign Improvement Activity scores based on APM design (no data submission required). We'll review each MIPS APM on a case-by-case basis, identify activities that are part of the design of the APMs that go with Improvement Activities, and assign the correlating Improvement Activity score to the APM Entity group.	• The Improvement Activities performance category weight = 20%.
Advancing Care Information performance category	• We've weighted the Advancing Care Information performance category for the 2017 performance period at 30% for the Medicare Shared Savings Program and the Next Generation ACO Model MIPS APMs. • For all other MIPS APMs we've weighted this performance category at 75% for the 2017 performance period.	• Use quality measure data reported through the APM. • Performance category weight = 50%. • Quality Improvement points will be available beginning in the 2018 performance year for any APM Entity for which 2017 quality performance data are available.
Cost performance category	• The Cost performance category weight = 0%.	• The Cost performance category weight = 0%

Q&A

Question 1

Q - What is considered a “complex patient”?

A - As defined by CMS: A complex patient is based on the combination of the dual eligibility ratio and the average Hierarchical Conditions Category (HCC) risk score.

Dual eligible beneficiaries is the general term that describes individuals who are enrolled in both Medicare and Medicaid. Have been identified as high-risk when compared to other patients with similar disease profile.

CMS calculates scores using claims.

Note: MIPS eligible clinicians must submit data on at least one measure or activity in a performance category to receive the complex patient bonus.

Q&A

Question 2 & 3

Q - Will the topped out measures be removed after the 4 years ?

A - Yes, at the end of the 4-year phase out period, the measures will no longer "earn points" towards your Quality score, as defined by CMS.

Q - How do you opt to participate in the cost feedback report?

A - (Will answer after obtaining clarification of question)